Draft Version

COBRA

What's New for 2006

Medical
Pharmacy
Dental
Vision
Behavioral Health

Open Enrollment 2006 ■ November 8-November 25

Notes

WHAT?

Open Enrollment

WHO?

All eligible COBRA participants.

WHAT'S NEW?

MEDICAL PLANS

Several changes to the medical plan offerings, copayments and exclusions of certain services have been made.

- The CIGNA Point-of-Service (POS) High and Low Option plans, the Preferred Provider Organization (PPO) High and Low Option plans and the HealthSelect High Option plan will not be offered effective Jan. 1, 2006.
- These plans have been replaced with the CIGNA HMO Independent Physician's Association (IPA) plan, the Open Access Plus (OAP) High and Low Option plans and a high-deductible health plan called CIGNA Choice Fund that offers a Health Savings Account.
- The HMO CIGNA Medical Groups (CMG) High and Low Option plans and HealthSelect Low Option plan, which includes an expanded provider network, continue to be offered.
- Summaries of the plan designs, your cost for services for each plan and plan exclusions are located in the "Medical Plan Choices" section.

PHARMACY PLANS

Two pharmacy plans, the Coinsurance plan and the Consumer Choice plan, continue to be offered through Walgreens Health Initiatives (WHI) for all medical plans except for the CIGNA Choice Fund Health Savings Account which has pharmacy benefit coverage through CIGNA.

- For both pharmacy plans administered by WHI, a mandatory 90-day supply for maintenance medications will be required at either specific retail pharmacies or through Walgreens Mail Service following two 30-day prescription fills of the same medication.
- The Consumer Choice plan's pharmacy account (Level 1) and deductible (Level 2) have been increased.
- The clinical prior authorization program has been expanded to include certain narcotic medications and anti-depressants.
- Changes to the preferred medication list for analgesics, hypertension medications and diabetic supplies are also anticipated. Specific details were not available at the time this document was produced. You may call the Benefits Office at 602-506-1010 for specifics on or after Oct. 7.

More detail regarding the pharmacy benefits is listed under the "Pharmacy Plans for All Medical Plans Except the Health Savings Account" section.

DENTAL PLANS

The dental options have been expanded to three choices.

- The United Concordia PPO Dental plan has been replaced with two PPO plans: CIGNA Dental and Delta Dental.
- Employers Dental Services (EDS) continues to be offered.

Information about these plans is listed under the "Dental Plans" section.

DISEASE MANAGEMENT

New disease management programs, which target obesity and weight management, have been added for all medical plans except HealthSelect.

PREMIUM RATES

- An incentive has been added for non-tobacco using employees who will enjoy lower premium rates.
- Premium rates have changed for medical, pharmacy, vision, behavioral health/substance abuse, and dental and are listed under the "Premium Rates" section.

OPEN ENROLLMENT PERIOD
This Open Enrollment period, your benefit elections and premium rates are effective for an 18-month period, beginning Jan. 1, 2006 and ending June 30, 2007. The next opportunity you will have to make benefit plan election changes will be effective July 1, 2007.

WHAT HAPPENS IF I DON'T COMPLETE OPEN ENROLLMENT?

MEDICAL and PHARMACY
You are encouraged to review your current benefit elections because if you do not complete an Open Enrollment election, you and your currently enrolled dependents will be enrolled in your current medical benefit plan, if that plan is still being offered, and your current pharmacy benefit plan.
If your current medical plan is no longer offered, you will be enrolled in the medical plan most similar to your current plan as shown below.

- If you are currently enrolled in the POS High Option or HealthSelect High or Low Option plans, you will be enrolled in the HMO IPA plan.
- If you are currently enrolled in the POS Low Option, you will be enrolled in the OAP Low Option plan.
- If you are enrolled in the PPO High Option plan, you will be enrolled in the OAP High Option plan.
- If you are enrolled in the PPO Low Option plan, you will be enrolled in the CIGNA Choice Fund Health Savings Account and the CIGNA pharmacy benefit.

DENTAL
If you are currently enrolled in the United Concordia Dental plan, you will be enrolled in the CIGNA Dental option.

TOBACCO USER RATES
If you do not complete an Open Enrollment election, it will be assumed that you are a tobacco user and you will be charged a higher premium rate than for a non-tobacco user.

WHEN?

Tuesday, Nov. 8 to Friday, Nov.25, 2005

The benefit plan period begins Jan. 1, 2006 and ends June 30, 2007. All changes made during open enrollment are effective Jan. 1, 2006.

HOW?

Your open enrollment information must be received by the COBRA Administrator no later than Nov. 25, 2005. Late enrollments will not be accepted. You are responsible for getting the form to the COBRA Administrator by Nov. 25. Delivery by this date will be ensured if the form is postmarked by Nov. 25, 2005 and mailed via U.S. Postal Service or hand-delivered to the COBRA Administrator's Office and date-stamped by a COBRA Plan representative by Nov. 25, 2005.

WHERE DO I GET ADDITIONAL INFORMATION NOT CONTAINED IN THIS GUIDE?

While most of the information you need is contained in this guide, other pertinent information is available online at the Benefits Home page located at http://www.maricopa.gov/benefits.The Benefit vendors are your primary and best source of information regarding the plans they offer. Refer to the "Who to Contact" section for their telephone numbers and Web site addresses.

QUESTIONS?

For questions regarding your benefits or premium rates, contact the COBRA Administrator, Compusys, at 602-234-0497.

Open Enrollment Checklist

- ❑ Review all of your current benefit elections, including, your dependents' names, birth dates and status (child or student, married, etc.), and your address to determine if changes are needed.
- ❑ Carefully read the information in this guide.
- ❑ Do not make a medical or dental election solely on the basis of a healthcare provider's participation with the vendor's network because physicians and dentists may stop participating during the plan year. If a specific physician or dentist is very important to you, consider selecting a product with out-of-network benefits such as an Open Access Plus (OAP) medical plan and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to see providers who no longer participate with the vendor's network, at higher out-of-pocket costs to you. Additionally, you should not make your medical election solely on the basis of specific medications on the preferred medication list (formulary) because medications may change their coverage status during the plan year. For example, medications may change from preferred brand name level to a generic or non-preferred brand name level, or may become available over-the-counter and therefore will not be covered by your pharmacy benefit.
- ❑ Make your election decisions carefully as they cannot be changed until **July 1, 2007.** You may change your Open Enrollment elections as many times as you want during the Open Enrollment period. However, changes to your elections cannot be accepted past the Open Enrollment closing date of Nov. 25, 2005.
- ❑ Complete your benefit elections no later than 5 p.m., Nov. 25, 2005. Once all enrollment elections are finalized by the COBRA Administrator following Nov. 25, 2005, confirmation statements will be produced and mailed to you in early to mid-December.
- ❑ Keep a copy of your election form as your verification of your Open Enrollment elections. Keep this page for verification purposes to compare with your confirmation statement in the event of an error..
- ❑ Review your confirmation statement immediately and contact the COBRA Administrator no later than Dec. 31, 2005, if you discover an error. Only errors will be corrected. Your copy of the Benefits Enrollment Open Enrollment form will be accepted as verification of your Open Enrollment elections in the event of an error.
- ❑ After Jan. 1, 2006, contact your selected medical plan vendor to change your primary care provider (PCP), if applicable. PCP changes are not available through Employee Self Service.
- ❑ Watch for your new ID card in the mail and upon receipt, be sure to check that your PCP selection is correctly displayed.
- ❑ Destroy your old ID card upon receipt of your new card. If additional cards are needed, contact the vendor directly either by phone or through their Web site. See the "Who to Contact" section.

  CIGNA Medical Plans:

  HMO CMG Low Option: Current enrollees <u>will not</u> receive new ID cards. New enrollees and dependents will receive new ID cards.

  HMO CMG High Option: Current and new enrollees will receive new ID cards due to copay changes.

  HMO IPA: Since this is a new plan, all enrollees and dependents will receive new ID cards.

  OAP High and Low Option: Since these are new plans, two new ID cards will be sent to employees who enroll in family coverage. Employees who enroll in single coverage will receive one ID card. Since a PCP is not required, dependents will not receive individual ID cards.

  HSA: Since this is a new plan, all enrollees and dependents will receive new ID cards.

  HealthSelect: Current and new enrollees and dependents will receive new ID cards.

  Avesis (vision): All enrollees will receive two new ID cards containing the employee's name, level of coverage, and an Avesis alternate ID number consisting of 8 numbers and a letter at the end. No dependent names will be listed on the cards.

CIGNA Dental: All enrollees will receive a generic dental ID card containing no personalized information. Enrollees with family coverage will receive two ID cards.

Delta Dental: All enrollees will receive two ID cards. The cards contain the name of the employee but not the name of the dependent.

EDS dental: All current and new enrollees will receive two new ID cards. No cards are issued to dependents.

Changing Medical Insurance Vendors?

If you're thinking of changing from HealthSelect to CIGNA, or vice versa, or are changing from another medical insurance vendor to a Maricopa county plan, consider the following:

- ❑ You may need to select a new primary care physician (PCP. If so, contact your selected medical plan vendor after Jan. 1, 2006 to change your PCP. Have your current PCP and any specialists send medical records to your new PCP as soon as possible after Jan. 1, 2006.
- ❑ Your existing PCP or specialist may require you to sign a medical release to have your medical records sent to the new PCP.
- ❑ Make an appointment as soon as possible for shortly after Jan. 1, 2006 to establish a relationship with your new PCP. Do not wait until there is a health crisis before making contact.
- ❑ With the help of your existing PCP, determine whether your supply of medication will last until you are able to see your new PCP. If not, ask for a prescription with a sufficient number of refills. All current enrollees are eligible to receive a 90-day supply of maintenance medication at many retail pharmacies as part of their pharmacy benefit.
- ❑ For you or a family member with a special need, contact CIGNA's member services department for help in transitioning care. Special needs may include:
  - ➢ High-risk or third trimester pregnancies
  - ➢ Chronic illness such as diabetes or congestive heart failure
  - ➢ Chemotherapy and/or radiation therapy
  - ➢ Durable medical equipment, such as wheelchairs, walkers, oxygen equipment, etc.
  - ➢ Organ or tissue transplantation services in process
  - ➢ Home health services
  - ➢ Post-surgical visits after the plan effective date
  - ➢ Scheduled elective surgeries
- ❑ CIGNA may request that you complete a Transition of Care form. This form is available in the forms section of the Benefits Home page.
- ❑ Let your providers know you have changed insurance carriers and show your new ID card(s) to your PCP and specialist. New ID cards will arrive shortly before Jan. 1.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Medical Plan Choices

This section provides a brief summary of information on the different medical plans offered, how they operate and the costs of services. For more detailed information, please contact the CIGNA Pre-Enrollment Phone Number listed in the "Who to Contact" section. Choices include HealthSelect, a managed-care plan, CIGNA HMO CMG and CIGNA HMO IPA, health maintenance organization (HMO) plans, Open Access Plus (OAP) plans, which are similar to a Preferred Provider Organization (PPO) plan, and a high deductible health plan, CIGNA Choice Fund, with an optional Health Savings Account. Some plans have a high and a low option from which to choose. You will select your pharmacy benefit separately from your medical plan. Major plan changes to copayments and coinsurance for existing plans are shaded for your information. New plan copayments and coinsurance are shaded, in comparison to the most similar discontinued plan. Please review the copayments and coinsurance of the new plans carefully. Exclusions to all of the CIGNA medical plans include bariatric surgery, abdominoplasty, panniculectomy, breast reduction, erectile dysfunction, and self-injectable medications, except for insulin. Self-injectable medication must now be purchased through your pharmacy benefit.

HealthSelect

Type of Plan: HealthSelect is a managed-care plan sponsored by Maricopa County and administered by CIGNA.
Service Area: Services may be received only within Maricopa County, except for emergency care.
Residency Requirement: None.
PCP Required? Yes. All care is directed through a primary care physician (PCP) — family practice, pediatrician, or internist.
Referrals Required?: Yes. Referrals are required from your PCP for all care except primary care, obstetrician/gynecologist services, urgent care, emergency care, chiropractic care and alternative medicine services.
Out-of-Network Coverage? No. All services must be received within the network, except for emergency services. The cost of services received by a non-network provider is your liability.
Network: Uses the CIGNA IPA network of physicians who practice in their own private practice offices and independently contract with CIGNA. The CIGNA Medical Groups are also included in this network. Maricopa Medical Center, the Family Health Centers (FHCs) and the Comprehensive Health Center (CHC) will be included in this network as soon as the contracts with CIGNA are approved by the Special Health Care District.
Precertification Requirements? Precertification is the responsibility of the IPA network provider.
Provider Directory: : To see a list of practitioners and hospitals participating in the IPA network, pick up a provider directory titled "CIGNA Healthcare of Arizona - CIGNA Care Network" at a Paper Depot or go online to www.mycigna.com or www.cigna.com and select the Provider Directory link, enter your physician search requirements and click the "Continue" button. On the next page, under the "Select your benefit plan or program" option, choose "Network (HMO) Plans or Point of Service (POS) Plans." From the "Network and Point of Service Plans above" drop-down list, select AZ - Arizona, and continue with the prompts. Leave "Do you have the CIGNA Care Network…" defaulted to "No". You can also call CIGNA's customer service department at 1-800-244-6224 and ask if a provider is participating in network AZ801.
High/Low Options: The HealthSelect plan has only one option offered for 2006 that is comparable to the HealthSelect Low Option plan offered in 2005. The High Option plan that was offered in 2005 will not be available beginning Jan. 1, 2006.
Major Plan Changes: Major plan changes to the HealthSelect plan offered for 2006 are shaded for your information as compared to the HealthSelect Low Option plan offered in 2005. Please note that all copayments have changed when compared to the HealthSelect High Option plan offered in 2005

HealthSelect

Benefit Provision		**HealthSelect: In-Network Coverage Only**
Deductible	Individual Family	None None
Standard Coinsurance Percentages		100% unless otherwise noted
Out-of-Pocket Maximum	Individual Family	$5,000 $10,000
Lifetime Maximum		None
Pre-existing Condition Limitation		None
General Services		
Preventive Care		$25
Primary Care Physician Services		$25
Specialty Care Physician Services		$45
MRI, MRA, CAT and PET Scans		$100 per procedure
Outpatient Lab and X-ray		$0
Inpatient Facility Charges		$500 per admission, then 90%
Inpatient Physician and Surgeon's Services		$0
Outpatient Surgery		$250, then 90%
Maternity		
Pre & Postnatal Exams (after pregnancy has been determined)		$45, waived after 1st visit
Delivery		$500, then 90%
Urgent and Emergency Services		
Urgent Care Facility		$50, waived if admitted
Other Facility – Emergency Room		$100, waived if admitted
Ambulance		$0 if emergency, otherwise not covered

Equipment and Devices	
Durable Medical Equipment	$0, $3,500 maximum\yr.
External Prosthetics	$200 separate deductible, $3,000 maximum\yr.
Outpatient Rehabilitation	
Cardiac and Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy	$45 per visit; 60 visits combined maximum/yr.
Chiropractic Services	$45 per visit; 20 visits/yr.
Alternative Medicine	$25 per visit; 12 visits/yr.; $60 credit for supplies/products

CIGNA HMO CMG

(Health Maintenance Organization, CIGNA Medical Groups)
High and Low Options

Type of Plan: CIGNA HMO CMG is a health maintenance organization plan insured by CIGNA.
Service Area: Services may be received only within Maricopa County, except for emergency care.
Residency Requirement: You must work or reside in Maricopa County to be eligible to enroll in this plan.
PCP Required? Yes. All care is directed through a primary care physician (PCP) — family practice, pediatrician, or internist - who practices in one of the 17 CIGNA Medical Group facilities. PCPs that practice in their private offices outside of the CMG facilities are not included in this plan. If you wish to see PCPs who practice in their private offices, you should select the HMO IPA plan or the OAP plan.
Referrals Required?: Yes. Referrals are required from your PCP for all care except primary care, obstetrician/gynecologist services, urgent care, emergency care, chiropractic care and alternative medicine services.
Out-of-Network Coverage? No. All services must be received within the HMO CMG network, except for emergency services. The cost of services received by a non-network provider is your liability.
Network: Uses the CIGNA CMG network of PCPs and certain specialists who practice in the CMG facilities. Some specialty care is referred out to private practice specialists by the CMG physician.
Precertification Requirements? Precertification is the responsibility of the HMO CMG network provider.
Provider Directory: For a list of practitioners and hospitals participating in the CIGNA HMO CMG network, pick up a provider directory titled "The Many Faces of CIGNA Medical Group" at one of the Paper Depots or go online to www.mycigna.com or www.cigna.com. From the home page, select the Provider Directory link, enter your physician search requirements and click the "Continue" button. On the next page, under the "Select your benefit plan or program" option, choose "Network (HMO) Plans or Point of Service (POS) Plans." From the "Network and Point of Service Plans above" drop-down list, select AZ - CIGNA Medical Group, and continue with the prompts. Leave "Do you have the CIGNA Care Network…" defaulted to "No". You can also call CIGNA's customer service department at 1-800-244-6224 and ask if a provider is participating in network AZ812.
High/Low Options: The CIGNA HMO CMG plan operates as described above for both the high and low options. The difference between the high and low options is in the amount of copays and/or coinsurance, and premium rates.
Major Plan Changes: The major changes to the HMO CMG High and Low Option plans offered for 2006 are shaded for your information.

HMO CMG High Option

Benefit Provision		**HMO CMG High Option: In-Network Coverage Only**
Deductible	Individual Family	None None
Standard Coinsurance Percentages		100%
Out-of-Pocket Maximum	 Individual Family	Includes inpatient and outpatient facility copays only; deductibles are not included $1,000 $2,000
Lifetime Maximum		None
Pre-existing Condition Limitation		None
General Services		
Preventive Care		$10

Mammograms, PSA and Pap Test	$0
Primary Care Physician Services	$10
Specialty Care Physician Services	$20
MRI, MRA, CAT and PET Scans	$50 per procedure
Outpatient Lab and X-ray	$0
Inpatient Facility Charges	$0
Inpatient Physician and Surgeon's Services	$0
Outpatient Surgery	$0
Maternity	
Pre- & Postnatal Exams (after pregnancy has been determined)	$20, waived after 1st visit
Delivery	$0
Urgent and Emergency Services	
Urgent Care Facility	$35 if urgent, otherwise not covered; copay waived if admitted
Other Facility – Emergency Room	$75 if emergency, otherwise not covered; copay waived if admitted
Ambulance	$0
Equipment and Devices	
Durable Medical Equipment	$0, $3,500 maximum\yr.
External Prosthetics	$200 deductible; $3,000 maximum\yr.
Outpatient Rehabilitation	
Cardiac and Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy	$20 per visit; 60 visits combined maximum/yr.
Chiropractic Services	$20 per visit; 20 visits/yr.
Alternative Medicine	$10 per visit; 10 visits/yr.; $60 credit for supplies/products

HMO CMG Low Option

Benefit Provision		**HMO CMG Low Option: In-Network Coverage Only**
Deductible	Individual Family	None None
Standard Coinsurance Percentages		100%
Out-of-Pocket Maximum	 Individual Family	Includes inpatient and outpatient facility copays and coinsurance $5,000 $10,000
Lifetime Maximum		None
Pre-existing Condition Limitation		None
General Services		
Preventive Care		$25
Mammograms, PSA, Pap Test		$0
Primary Care Physician Services		$25
Specialty Care Physician Services		$45
MRI, MRA, CAT and PET Scans		$100 per procedure
Outpatient Lab and X-ray		$0
Inpatient Facility Charges		$500 per admission, then 90%
Inpatient Physician and Surgeon's Services		$0
Outpatient Surgery		$250, then 90%
Maternity		
Pre- & Postnatal Exams (after pregnancy has been determined)		$45, waived after 1st visit
Delivery		$500, then 90%

Urgent and Emergency Services	
Urgent Care Facility	$50 if urgent, otherwise not covered; copay waived if admitted
Other Facility – Emergency Room copay	$100 if emergency, otherwise not covered; copay waived if admitted
Ambulance	$0
Equipment and Devices	
Durable Medical Equipment	$0, $3,500 maximum\yr.
External Prosthetics	$200 deductible; $3,000 maximum\yr.
Outpatient Rehabilitation	
Cardiac and Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy	$45 per visit; 60 visits combined maximum/yr.
Chiropractic Services	$45 per visit; 20 visits/yr.
Alternative Medicine	$25 per visit; 10 visits/yr.; $60 credit for supplies/products

CIGNA HMO IPA (INDEPENDENT PHYSICIAN'S ASSOCIATION)

Type of Plan: CIGNA HMO IPA is a health maintenance organization plan insured by CIGNA.
Service Area: Services may be received within Arizona, except for emergency care.
Residency Requirement: You may reside anywhere in Arizona to be eligible to enroll in this plan.
PCP Required? Yes. All care is directed through a primary care physician (PCP) — family practice, pediatrician, or internist - who practices in his/her private practice office.
Referrals Required?: Yes. Referrals are required from your PCP for all care except primary care, obstetrician/gynecologist services, urgent care, emergency care, chiropractic care and alternative medicine services.
Out-of-Network Coverage? No. All services must be received within the network, except for emergency services. The cost of services received by a non-network provider is your liability.
Network: Uses the IPA network of physicians who practice in their own private practice offices and independently contract with CIGNA. The CIGNA Medical Groups are also included in this network. Maricopa Medical Center, the Family Health Centers (FHCs) and the Comprehensive Health Center (CHC) will be included in this network as soon as the contracts with CIGNA are approved by the Special Health Care District.
Precertification Requirements? Precertification is the responsibility of the network provider.
Provider Directory: To see a list of practitioners and hospitals participating in the IPA network, pick up a provider directory titled "CIGNA Healthcare of Arizona - CIGNA Care Network" at a Paper Depot or go online to www.mycigna.com or www.cigna.com and select the Provider Directory link, enter your physician search requirements and click the "Continue" button. On the next page, under the "Select your benefit plan or program" option, choose "Network (HMO) Plans or Point of Service (POS) Plans." From the "Network and Point of Service Plans above" drop-down list, select AZ - Arizona, and continue with the prompts. Leave "Do you have the CIGNA Care Network…" defaulted to "No". You can also call CIGNA's customer service department at 1-800-244-6224 and ask if a provider is participating in network AZ801.
High/Low Options: The CIGNA HMO IPA has only one option. There is not a high and low option offered.
Major Plan Changes: As the HMO IPA plan is a new plan offered effective Jan. 1, 2006, the changes that are highlighted are in comparison to the discontinued Point of Service High Option plan that was offered in 2005.

HMO IPA

Benefit Provision		**HMO IPA: In-Network Coverage Only**
Deductible	Individual Family	None None
Standard Coinsurance Percentages		100%
Out-of-Pocket Maximum	 Individual Family	Includes inpatient and outpatient facility copays only; does not include deductibles $1,000 $2,000
Lifetime Maximum		None
Pre-existing Condition Limitation		None
General Services		
Preventive Care		$20
Mammograms, PSA, Pap Test		$0
Primary Care Physician Services		$20
Specialty Care Physician Services		$30
MRI, MRA, CAT and PET Scans		$100 per procedure
Outpatient Lab and X-ray		$0
Inpatient Facility Charges		$100 per day; $300 maximum per admission
Inpatient Physician and Surgeon's Services		$0
Outpatient Surgery		$100
Maternity		
Pre- & Postnatal Exams (after pregnancy has been determined)		$30, waived after 1st visit
Delivery		$100 per day; $300 maximum per admission
Urgent and Emergency Services		
Urgent Care Facility		$50 if urgent, otherwise not covered; copay waived if admitted.
Other Facility – Emergency Room copay		$100 if emergency, otherwise not covered; copay waived if admitted.
Ambulance		$0 if emergency, otherwise not covered
Equipment and Devices		
Durable Medical Equipment		$0, $3,500 maximum\yr.
External Prosthetics		$200 deductible, $3,000 maximum\yr.
Outpatient Rehabilitation		
Cardiac and Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy		$30 per visit; 60 visits combined maximum/yr.
Chiropractic Services		$30 per visit; 20 visits/yr.
Alternative Medicine		$20 per visit; 10 visits/yr.; $60 credit for supplies/products

CIGNA OAP (OPEN ACCESS PLUS) HIGH AND LOW OPTIONS

Type of Plan: CIGNA Open Access Plus is a self-directed in- and out-of-network plan (much like a PPO plan) insured by CIGNA.
Service Area: Services may be received nationally.
Residency Requirement: None
PCP Required? No.
Referrals Required? No
Out-of-Network Coverage? Yes. Services may be received by a non-network provider. Services received through non-network providers typically cost you more because the coverage amount is based on reasonable and customary charges within the geographic area. Fees above reasonable and customary amounts are your liability in addition to your coinsurance and deductible amounts.
Network: Uses the CIGNA national IPA network of physicians who practice in their own private practice offices and independently contract with CIGNA. The CIGNA Medical Groups are also included in this network. Maricopa Medical Center, the Family Health Centers (FHCs) and the Comprehensive Health Center (CHC) will be included in this network as soon as the contracts with CIGNA are approved by the Special Health Care District.
Precertification Requirements? Precertification is the responsibility of the network provider when services are received in-network. Precertification is your responsibility when services are received from a non-network provider. A non-compliance penalty of 50% for hospital inpatient and certain outpatient charges is applied for failure to complete the precertification process. Benefits are denied for admissions or additional days reviewed and not certified by CIGNA.
Provider Directory: To see a list of practitioners and hospitals participating in the IPA network, pick up a provider directory titled "CIGNA Healthcare of Arizona – CIGNA Care Network" at a Paper Depot or go online to www.mycigna.com or www.cigna.com and select the Provider Directory link, enter your physician search requirements and click the "Continue" button. On the next page, under the "Select your benefit plan or program" option, choose "Open Access Plus Only". Do not use the "Network and Point of Service Plans above" drop-down list. Continue with the prompts. Leave "Do you have the CIGNA Care Network…" defaulted to "No". You can also call CIGNA's customer service department at 1-800-244-6224 and ask if a provider is participating in network AZ801.
High/Low Options: The CIGNA OAP plan operates as described above for both the high and low options. The difference between the high and low options is in the amount of copays and/or coinsurance, and premium rates.
Major Plan Changes: As the OAP High and Low Option plans are new plans offered effective Jan. 1, 2006, the changes that are highlighted are in comparison to the discontinued applicable Point of Service plan that was offered in 2005.

OAP High Option

Benefit Provision		**OAP High In-Network Coverage**	**OAP High Out-of-Network Coverage**
Deductible	Individual Family	None None	$300 $600
Standard Coinsurance Percentages		100%	70% of reasonable and customary
Out-of-Pocket Maximum	 Individual Family	Does not apply to deductibles or copays. $1,000 $2,000	Does not apply to non-compliance penalties, deductibles, copays or charges in excess of reasonable and customary $3,000 $6,000
Lifetime Maximum		None	None
Pre-existing Condition Limitation		12 months for treatment in prior 90 days. Waived for initial group or with certificate of creditable coverage.	
General Services			
Preventive Care		$25	Covered in-network only
Mammograms, PSA, Pap Test		$0 if billed by an independent diagnostic facility or outpatient hospital	70% after deductible

Primary Care Physician Services	$25	70% after deductible
Specialty Care Physician Services	$35	70% after deductible
MRI, MRA, CAT and PET Scans	$50 per procedure, any place of service	70% after deductible; precertification may be required
Outpatient Lab and X-ray	$0	70% after deductible
Inpatient Facility Charges	$200 per admission	70% after deductible; precertification required
Inpatient Physician and Surgeon's Services	$0	70% after deductible
Outpatient Surgery	$100\visit	70% after deductible; precertification required
Maternity		
Pre-& Postnatal Exams (after pregnancy has been determined)	$35, waived after 1st visit	70% after deductible
Delivery	$200	70% after deductible; precertification required
Urgent and Emergency Services		
Urgent Care Facility	$50, waived if admitted	$50 if urgent; waived if admitted; otherwise 70% after deductible
Other Facility – Emergency Room	$100, waived if admitted	$100, if emergency, waived if admitted; otherwise 70% after deductible
Ambulance	$0	$0 if emergency, otherwise 70% after deductible
Equipment and Devices		
Durable Medical Equipment	$0; $3,500 maximum\yr.	70% after deductible; $3,500 maximum\yr.
External Prosthetics	$200 deductible; $3,000 maximum\yr.	$200 deductible, then 70% after plan deductible; $3,000 max\yr.
Outpatient Rehabilitation		
Cardiac and Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy and Chiropractic Services	$35 per visit; 60 visits combined maximum/yr.	70% after deductible; 60 visits combined maximum/yr
Alternative Medicine	$25 per visit; 10 visits/yr.; $60 credit for supplies/products	Covered in-network only

OAP Low Option

Benefit Provision		**OAP Low In-Network Coverage**	**OAP Low Out-of-Network Coverage**
Deductible	Individual Family	None None	$1,000 $2,000
Standard Coinsurance Percentages		90%	70%
Out-of-Pocket Maximum	Individual Family	$5,000 $10,000	$10,000 $20,000
Lifetime Maximum		None	None
Pre-existing Condition Limitation		12 months for treatment in prior 90 days. Waived for initial group or with certificate of creditable coverage.	
General Services			
Preventive Care		$35	Covered in-network only
Mammograms, PSA, Pap Test		90%	70% after deductible
Primary Care Physician Services		$35	70% after deductible
Specialty Care Physician Services		$50	70% after deductible
MRI, MRA, CAT and PET Scans		90%	70% after deductible

Outpatient Lab and X-ray	90%	70% after deductible
Inpatient Facility Charges	$1,000 per admission, then 90%	$2,000 per admission, then 70%; precertification required
Inpatient Physician and Surgeon's Services	90%	70% after deductible
Outpatient Surgery	$500, then 90%	$1,000, then 70% after deductible; precertification required
Maternity		
Pre- & Postnatal Exams (after pregnancy has been determined)	$50, then 90%	70% after deductible
Delivery	$1,000, then 90%	$2,000, then 70% after deductible; precertification required
Urgent and Emergency Services		
Urgent Care Facility	$75, waived if admitted	$75 if urgent; waived if admitted; otherwise 70% after deductible
Other Facility – Emergency Room	$150, waived if admitted	$150, if emergency, waived if admitted; otherwise 70% after deductible
Ambulance	90%	90% if true emergency, otherwise 70% after deductible
Equipment and Devices		
Durable Medical Equipment	$0; $3,500 maximum\yr.	70% after deductible; $3,500 maximum\yr.
External Prosthetics	$200 deductible; $3,000 maximum\yr.	$200 deductible, then 70% after plan deductible; $3,000 maximum\yr.
Outpatient Rehabilitation		
Cardiac and Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy and Chiropractic Services	$50 per visit; 60 visits combined maximum/yr.	70% per visit after deductible, 60 visits combined maximum/yr.
Alternative Medicine	$35 per visit; 10 visits/yr.; $60 credit for supplies/products	Covered in-network only

CIGNA CHOICE FUND HEALTH SAVINGS ACCOUNT (HSA)

Type of Plan: CIGNA Choice Fund is a consumer-driven health plan that combines a health savings account with a high-deductible medical plan. The optional savings account is administered through JPMorgan Chase and funds in the account can be used to pay for qualified medical expenses (per IRS 213) with convenient access to your funds through either a debit card or checkbook. You can make tax-free payroll contributions to your account up to the deductible amount. You can also make direct deposits to the fund on a post-tax basis. Six mutual funds are available for your investment options. Unused balances in your account are rolled over and continue to accrue interest. If you leave employment you take unused dollars with you.

With an HSA, you take a more active role in your health care by understanding your choices and making informed decisions as you learn to seek quality, cost-effective care. A variety of resources are available to assist you with decision making through mycigna.com such as decision support tools powered by WebMD® and health care management resources to help when you are sick and to help you stay well. Additional tools can help you estimate out-of-pocket expenses, check account balances, compare medications, and more.

To be eligible to enroll in the CIGNA Choice Fund HSA, you may not be covered by other health insurance including Medicare Parts A or B.

Service Area: Services may be received nationally.

Residency Requirement: None

PCP Required? No.

Referrals Required? No

Out-of-Network Coverage? Yes. Services may be received by a non-network provider. Services received through non-network providers typically cost you more because the coverage amount is based on reasonable and customary charges within the geographic area. Fees above reasonable and customary amounts are your liability in addition to your coinsurance and deductible amounts.

Network: Uses the CIGNA national PPO network of physicians who practice in their own private practice offices and independently contract with CIGNA. The CIGNA Medical Groups are also included in this network.

Precertification Requirements? Precertification is the responsibility of the network provider when services are received in-network. Precertification is your responsibility when services are received from a non-network provider. A non-compliance penalty of 50% for hospital inpatient charges is applied for failure to complete the precertification process. Benefits are denied for admissions or additional days reviewed and not certified by CIGNA.

Provider Directory: To see a list of practitioners and hospitals participating in the CIGNA PPO network, pick up a provider directory at a Paper Depot titled "Preferred Provider Network" or go online to www.mycigna.com or www.cigna.com and select the Provider Directory link from the home page, enter your physician search requirements and then click the "Continue" button. From the next page, in the "Select your benefit plan or program," option choose the "Preferred Provider Organizations (PPO)" and continue with the prompts. Do not enter any information in the "Network and Point of Service Plans above" drop-down list. Leave "Do you have the CIGNA Care Network…" defaulted to "No". You can call CIGNA's customer service department at 1-800-244-6224 and ask if a provider is participating in the PPO national network.

High/Low Options: The CIGNA Choice Fund has only one option. There is not a high and low option offered.

Major Plan Changes: As the CIGNA Choice Fund Health Savings Account plan is a new plan offered effective Jan. 1, 2006, the changes that are highlighted are in comparison to the discontinued Preferred Provider Organization (PPO) Low Option plan that was offered in 2005.

CIGNA Choice Fund Health Savings Account (HSA)

Benefit Provision		**Choice Fund HSA In-Network Coverage**	**Choice Fund HSA Out-of-Network Coverage**
Deductible	Individual Family	$1,100 $2,200	$1,100 $2,200
Standard Coinsurance Percentages		80%	60% of reasonable and customary
Out-of-Pocket Maximum	 Individual Family	Includes deductible and copays & coinsurance; does not include non-compliance penalties $5,000 $10,000	Includes deductible and copays & coinsurance; does not include non-compliance penalties or charges in excess of reasonable and customary $5,000 $10,000
Lifetime Maximum		$5,000,000 combined	$5,000,000 combined
Pre-existing Condition Limitation		12 months for treatment in prior 90 days. Waived for initial group or with certificate of creditable coverage.	
General Services			
Preventive Care-Well Baby, Well-child, through age 2, and Adult Preventive Care and immunizations		$0, deductible does not apply	Covered in-network only
Mammograms, PSA, Pap Test;		$0, deductible does not apply	60% after deductible
Primary Care Physician Services		80% after deductible	60% after deductible
Specialty Care Physician Services		80% after deductible	60% after deductible
MRI, MRA, CAT and PET Scans		80% after deductible	60% after deductible
Outpatient Lab and X-ray		80% after deductible; $0, no deductible if preventive	60% after deductible
Inpatient Facility Charges		80% after deductible	60% after deductible; precertification required
Inpatient Physician and Surgeon's Services		80% after deductible	60% after deductible
Outpatient Surgery		80% after deductible	60% after deductible
Maternity			
Pre- & Postnatal Exams (after pregnancy has been determined)		80% after plan deductible (initial and subsequent visits)	60% after plan deductible (initial and subsequent visits)
Delivery		80% after deductible	60% after deductible; precertification required
Urgent Care Facility		80% after deductible	80% after deductible if urgent, otherwise 60% after deductible
Urgent and Emergency Services			

Other Facility – Emergency Room		80% after deductible	80% after deductible if emergency, otherwise 60% after deductible
Ambulance		80% after deductible	80% after deductible if emergency, otherwise 60% after deductible
Equipment and Devices			
Durable Medical Equipment Unlimited maximum/yr.		80% after deductible	60% after deductible
External Prosthetics Unlimited max/yr		$200 deductible, then 80% after plan deductible	$200 deductible, then 60% after plan deductible
Outpatient Rehabilitation			
Cardiac and Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy and Chiropractic Services		80% after deductible; 60 visits combined maximum/yr.	60% after deductible, 60 visits combined maximum/yr.
Alternative Medicine		$5 per visit after deductible; 10 visits/yr.; $60 credit for supplies/products	Covered in-network only
Pharmacy Benefit through CIGNA pharmacy network or CIGNA Tel-Drug Uses CIGNA's Preferred Medication List		30% after deductible generic 40% after deductible preferred brand 50% after deductible non-preferred brand	Covered in-network only
CIGNA Behavioral Health	Inpatient	80% after deductible; 60 days combined maximum\yr.	60% after deductible; precertification required
	Outpatient	80% after deductible; 20 visits combined maximum\yr.	60% after deductible
	Intensive Outpatient	50% after plan deductible; maximum up to 3 programs\yr.	50% after deductible
Vision		Through Avesis	

Behavioral Health and Substance Abuse Plan

If you enroll in a medical plan, you must enroll in behavioral health & substance abuse benefits. Your behavioral health and substance abuse services continue to be provided by United Behavioral Health (UBH) unless you elect the CIGNA Choice Fund Health Savings Account. In that case, behavioral health and substance abuse services are provided by CIGNA Behavioral Health. Refer to the table of benefits in the "CIGNA Choice Fund Health Savings Account (HSA)" section.

Your behavioral health & substance abuse benefits have no deductible and in-network services are payable only if services are precertified by UBH before beginning treatment and services have been deemed medically necessary. Out-of-network outpatient services do not require precertification. There are no benefit changes to this plan for 2006.

	In-Network	**Out-of-Network**
Deductible	None	None
Inpatient hospital care, 30 days/yr.	$25/day	Not covered
Intensive outpatient program	$100 per program	Not covered
Outpatient Individual therapy visits (in- and out-of-network visit limit is combined; 30 visits/yr.)	$10/visit	Benefit pays $25/visit; you pay the balance of the charges
Outpatient group therapy visits (in- and out-of-network visit limit is combined; 60 visits/yr.)	$5/visit	Benefit pays $25/visit; you pay the balance of the charges
Residential treatment, 60 days/yr.	$12.50/day	Not covered
Behavioral health/substance abuse lifetime maximum	Unlimited	$5,000,000

Vision Plan

Your vision benefit for HealthSelect and all CIGNA medical plans continues to be provided through Avesis. If you enroll in a County medical plan, you must enroll in the vision benefit. The County also offers a separate (stand-alone) vision plan for employees who choose to waive their medical benefits but wish to enroll in the vision plan. There are no benefit changes to this plan for 2006.

Benefits	**In-Network Options Charges/Costs**		**Out-of-Network Charges/Costs**
	Option One Eyeglasses	Option Two Contact Lenses	
Routine Vision Exam	$10	$10	Maximum benefit $35
Single spectacle lenses (pair) includes polycarbonate, clear glass or CR39 basic plastic	$10		
Single Vision Lenses			Maximum benefit $25
Bifocal Lenses			Maximum benefit $40
Trifocal Lenses			Maximum benefit $50
Lenticular			Maximum benefit $80
Frame (within plan allowance)			Maximum benefit $45
Tints and Coatings	20% of reasonable & customary	Not applicable	Not covered
Contact Lenses-Elective as determined by Avesis	Not applicable	$130 allowance applied toward contact lenses &/or professional fitting fees. $10 for exam.	Maximum benefit: $130 applied toward contact lenses &/or professional fitting fees.
Contact Lenses-Medically necessary as determined by Avesis		$10 for exam	Maximum benefit: $250 applied toward exam, contact lenses and related professional fitting fees.
Option Three (LASIK Surgery Benefit)			
LASIK Surgery	One-time (lifetime) benefit. Takes the place of all other benefits for the benefit year. May be done only through an Avesis contracted provider. $150 allowance applies toward the cost of the LASIK surgery for one or both eyes.		Not covered

Pharmacy Plans for All Medical Plans except the Health Savings Account

If you enroll in a medical plan, you must enroll in a pharmacy plan. All medical plans, (HealthSelect, CIGNA HMO CMG, HMO IPA and OAP), except for CIGNA Choice Fund Health Savings Account have two pharmacy benefit plans from which to choose (Coinsurance plan and Consumer Choice plan). Both plans are administered through WHI with convenient pharmacy locations including Albertson's, Basha's, CIGNA Medical Group pharmacies (CMGs), CVS, Fry's, K-Mart, Osco, Safeway, Sam's Club, Target, Walgreens, and Wal-Mart. Many pharmacies have extended hours. The CIGNA Choice Fund Health Savings Account's pharmacy benefit has a CIGNA pharmacy plan. Refer to the "CIGNA Choice Fund Health Savings Account (HSA)" table of services for the pharmacy benefit coinsurance amounts.

For both plans, some medications require prior authorization, quantity limits apply to certain medications, and some drug classes, such as infertility and cosmetic medications, are excluded. While excluded medication is not covered under your plan, you may still purchase such medication and take advantage of our negotiated discounts.

For the Coinsurance plan, certain medications must be used in a certain order (step therapy). For the Consumer Choice plan, step therapy does not apply, but the pharmacist will receive a message advising to alert you in you've chosen a more expensive medication when a more cost effective medication is available.

After two 30-day fills, all maintenance medications for both pharmacy plans are required to be refilled through either Walgreens Mail Service or at certain retail pharmacies including Albertson's, Bashas, CVS, Frys, K-Mart, Osco, Safeway, Sam's Club, Target, Walgreens, and Wal-Mart. Refills ordered through mail service may be shipped to the location of your choice, such as work or to a local Walgreens retail store.

Both pharmacy plans offers financial protection by ensuring that an individual never pays more than $1,500 per plan year, and a family never pays more than $3,000 per plan year, for covered prescription medications regardless of your pharmacy plan choice. Once the annual maximum is met, all other covered prescriptions for the remainder of the plan year will be available at no cost to the individual and/or their family. Any number of family members contributes to the family out-of-pocket maximum.

The Coinsurance plan uses a preferred medication list, which can be found online at www.mywhi.com, or you can call WHI Customer Service at 1-800-207-2568 to have your specific questions answered. The Consumer Choice plan does not use a preferred medication list.

Coinsurance Plan
The coinsurance pharmacy benefit is a multi-level plan where a coinsurance (percentage of the cost of the medication) is charged (unless the applicable minimum or maximum threshold is met) based on the classification of the medication. In general, generic medications cost the least and non-preferred brand name medications cost the most. For each prescription filled, your physician can select from available generic, preferred brand name or non-preferred brand name medication.

Coinsurance 30-day Retail
Generic prescriptions: You are responsible for 25% coinsurance of the contracted cost.* The cost of each prescription will be at least $2 but no more than $12.
Preferred brand name prescriptions (on the preferred medication list): You are responsible for 30% coinsurance of the contracted cost.* The cost of each prescription will be at least $5 but no more than $30.
Non-preferred brand name prescriptions (not on the preferred medication list) with a generic equivalent: You are responsible for a 50% coinsurance of the contracted cost* plus the difference between the cost of the generic medication and the brand name medication. The cost of each prescription will be at least $20. There is no maximum amount for the cost of medication in this category.
Non-preferred brand name prescriptions (not on the preferred medication list) with no generic equivalent: You are responsible for 50% coinsurance of the contracted cost.* The cost of each prescription will be at least $20. There is no maximum amount for the cost of medication in this category.
Specialty pharmacy medications (not on the preferred medication list) with no generic equivalent: You are responsible for a $50 copay for specialty medications for complex health conditions. Specialty medications are received through the specialty pharmacy program, with an emphasis on expensive and difficult-to-find medications, injectables or other medications involving complex administration methods, strict compliance requirements, special storage, handling and delivery, education, monitoring and ongoing patient support. Patient

conditions which may require the use of specialty medications include acromegaly, chronic granulomatous disease, cystic fibrosis, gaucher disease, hemophilia, multiple sclerosis, HIV/AIDS, viral hepatitis, some oncology-related conditions, psoriasis, rheumatoid arthritis, growth hormone disorders, respiratory syncytial virus (RSV), solid organ transplant and deep vein thrombosis. Prescriptions for specialty medication filled at a retail pharmacy may only be filled at a Walgreens pharmacy.
*Contracted cost is the discounted average wholesale price of the prescription plus the dispensing fee.

Coinsurance Mail Service 84-91 day supply
Genetic prescriptions: You are responsible for 15% of the contract cost*, with a minimum of $6 and a maximum of $28.
Preferred brand name prescriptions (on the preferred medication list): You are responsible for 25% of the contract cost*, with a minimum of $15 and a maximum of $70.
Non-preferred brand name prescriptions (not on the preferred medication list) with a generic equivalent: You are responsible for 50% of the contract cost* plus the difference between the cost of the generic medication and the brand name medication. The cost of each 84-91 day prescription will be at least $60.There is no maximum amount for the cost of medication in this category.
Non-preferred brand name prescriptions (not on the preferred medication list) with no generic equivalent: You are responsible for 50% of the contract cost.* The cost of each 84-91 day prescription will be at least $60. There is no maximum amount for the cost of medication in this category.
Specialty pharmacy medications (not on the preferred medication list) with no generic equivalent: Specialty medications are not available in 84-91 day supplies, however these medications may be received through home delivery at the cost of $50 for a 30-day supply.
*Contracted cost is the discounted average wholesale price of the prescription plus the dispensing fee.

Consumer Choice Plan
The Consumer Choice pharmacy benefit is a multi-level plan where Maricopa County fully funds the first level pharmacy account, you fund the second level — which functions as a deductible — and you and Maricopa County share the cost of the third level (insurance) through coinsurance. The benefit is geared towards smart spending of all funds through the use of the most cost-effective medication. Any unused portion of the pharmacy account is rolled over to the next benefit year, creating a credit balance that you can use to pay for future prescription costs.
Pharmacy Account: The account is funded 100% by Maricopa County at the rate of $300 per individual or $500 per family. As prescriptions are purchased, the contracted cost* of the medication is debited against this account.
Deductible: The deductible is funded 100% by you at the rate of $300 per individual or $500 per family. As prescriptions are purchased, you pay 100% of the contracted cost* of the medication. If you have enrolled in the Mariflex health care FSA for 2006, you can use your pre-taxed funds to pay for medication costs purchased at this level.
Insurance: The insurance level covers the cost of the medication at 80% coinsurance based on the contracted cost* of the medication. You pay a 20% coinsurance of the contracted cost*.
Specialty pharmacy medications will not be charged against your pharmacy account or deductible. Instead, a $50 copay will be charged for each 30-day supply. These out-of-pocket expense will be applied toward the out-of-pocket maximums. You are responsible for a $50 copay for specialty medications for complex health conditions. Specialty medications are received through the specialty pharmacy program, with an emphasis on expensive and difficult-to-find medications, injectables or other medications involving complex administration methods, strict compliance requirements, special storage, handling and delivery, education, monitoring and ongoing patient support. Patient conditions which may require the use of specialty medications include acromegaly, chronic granulomatous disease, cystic fibrosis, gaucher disease, hemophilia, multiple sclerosis, HIV/AIDS, viral hepatitis, some oncology-related conditions, psoriasis, rheumatoid arthritis, growth hormone disorders, respiratory syncytial virus (RSV), solid organ transplant and deep vein thrombosis. Prescriptions for specialty medication filled at a retail pharmacy may only be filled at a Walgreens pharmacy.
The Consumer Choice pharmacy benefit may be used at either a retail pharmacy or through Walgreens Mail Service as described above.
*Contracted cost is the discounted average wholesale price of the prescription plus the dispensing fee.

DENTAL PLAN CHOICES

Maricopa County employees may purchase dental insurance from one of three dental vendors –Employers Dental Services (EDS), CIGNA Dental and Delta Dental. Dental coverage may be purchased even if you waive medical insurance coverage.

Employers Dental Services (EDS)
EDS is a managed care dental organization. With this type of plan, EDS prepays your dentist for your services on a monthly basis. Everyone who is covered under your plan chooses the same dentist. The network of dentists who participate in this plan is somewhat smaller than both other dental plans offered, however, you have the freedom to change dentists, with all changes received by the 20th of the month becoming effective the first of the following month.

There is no deductible, no claim forms, and no yearly maximums with this plan. The cost for diagnostic and preventive services, basic restoration services and major services is very reasonable when performed by a general dentist. Specialty care is not covered. Rather, it is provided at a discount, as is treatment of temporomandibular joint (TMJ) pain, and orthodontic services for children and adults.

Immediate coverage is available for basic, preventive and major services. EDS covers pre-existing conditions, except for procedures in progress at time of enrollment.

To review the list of practitioners participating in the EDS network, pick up a provider directory at a Paper Depot or go online to www.mydentalplan.net.

EDS Features	
Annual Year Maximum per person	None
Orthodontic Service	25% discount on all orthodontic services Covers adults and children Covers metal banding, invisible braces, and Invisalign braces, appliances such as expanders, reverse headgear, Herbst, Pendulum, Nance, Tongue Crib, Jaspers, Sagittal, and Schwartz. Prices on which the discount is calculated may vary by orthodontist.
Provider Network Access	Must see EDS network dentist. Out-of-network coverage is not available.
Deductible	None
Diagnostic and Preventive Services	At a general dentist: Office visit: $3 Routine oral exam: $0 Cleaning: $0 X-rays: $0 Sealants: $12/tooth Fluoride: $0 Emergency services: up to $200 reimbursement less applicable copay
Basic Restoration Services	At a general dentist: Fillings (amalgam): $8 - $21 Fillings (resin): $22 - $40 Oral surgery: from $35 Endodontics: root canal, $170-$265 Periodontics: debridement, $80; scaling and root planning/quadrant $90
Major Services	At general dentist: Crown porcelain with metal: $250 plus lab fee Complete dentures upper or lower: $325 for each plus lab fee Partial dentures upper or lower (resin base) $375 for each plus lab fee Bridge per pontic: $250 plus lab fee

CIGNA Dental PPO

CIGNA Dental gives you freedom of choice in selecting your dental provider by offering a product with **in-network and out-of-network benefits.** A dentist participating in CIGNA Dental's network will submit your claim, receive direct payment from CIGNA Dental and accept the fee as payment in full (after your deductible and/or coinsurance). Using a participating network dentist costs you less because services are covered at a higher percentage. In addition, network dentists have agreed to discount their services, on average, by 27%. Diagnostic & Preventive Services are covered 100% and Basic Restoration Services are covered at 80%. Major Services are covered at 50%.

If you use an out-of-network dentist, you can assign payments to that dentist by signing the claim form appropriately. If you do this, your dentist will likely submit the claim for you since this means CIGNA Dental will pay the dentist directly. If the dentist will not directly bill CIGNA Dental, you must submit the claim.

CIGNA Dental compensates all dentists according to its reasonable and customary allowance. Network dentists agree to accept these allowances as payment in full for covered services less applicable coinsurance and deductibles. Non-network dentists are under no obligation to accept the payment as full payment, and may bill you for the difference between the billed charges and CIGNA Dental's reasonable and customary allowance. Additionally, use of out-of-network dentists will cost more because services are covered at a lower percentage. Diagnostic & Preventive Services are covered at 80% and Basic Restoration is covered at 60%. Major Services are covered at 50%.

Provider Directory: To see a list of dentists participating in the PPO network, pick up a provider directory at a Paper Depot or go online to www.mycigna.com or www.cigna.com and select the Provider Directory link, select dentist, enter your search requirements and click the "Continue" button. On the next page, under the "Select your dental plan" option, choose "Managed care plan with open access to dentists CIGNA Dental PPO" and continue with the prompts. You can also call CIGNA's customer service department at 1-888-336-8258 and ask if a provider is participating in the PPO Dental network.

CIGNA Dental's Features	
Annual Year Maximum per person	$2,000
Orthodontic Service	Diagnostic, active and retention treatment: 50% Covers adults and children $3,000 lifetime maximum effective for treatment plans beginning on or after Jan. 1, 2005. Lifetime maximum will be coordinated with prior group insurance carrier; continuing services previously covered under a prepaid dental plan, such as EDS, will not be covered.
Provider Network Access	In-network and out-of-network providers are available.
Deductible	$50 per person/$100 per family (waived for diagnostic, preventive and orthodontic services) combined for in- and out-of-network services.
Diagnostic and Preventive Services	100% coverage for diagnostic, preventive, and palliative services Routine oral exam/cleanings twice per year X-rays (limits apply) Sealants of permanent molars (through age 15) Fluoride: twice per year through age 18 Space maintainers Emergency care to relieve pain In-network 100% of maximum allowable charges Out-of-network 80% of reasonable and customary allowance plus excess charges

	required by dentist*
Basic Restoration Services	Amalgam fillings on posterior teeth Resin/composite fillings on anterior teeth Endodontics Periodontics Repair of denture and bridgework Simple extractions Complex oral surgery General anesthesia In-network 80% of allowable charges, after deductible Out-of-network 60% of reasonable and customary allowance, after deductible plus excess charges required by dentist*
Major Services	Resin/composite fillings on posterior teeth Inlays, onlays, and crowns Complete or partial dentures Fixed bridges In-network 50% of allowable charges, after deductible Out-of-network 50% of reasonable and customary allowance, after deductible plus excess charges required by dentist*

*If the out-of-network dentist charges more than the reasonable and customary allowance, you are liable for the difference between the allowance and the billed amount, in addition to your deductible and coinsurance.

Delta Dental
Delta Dental gives you freedom of choice in selecting your dental provider by offering a product with **in-network and out-of-network benefits.** A dentist participating in Delta Dental's network will submit your claim, receive direct payment from Delta Dental and accept the fee as payment in full (after your deductible and/or coinsurance). Using a network dentist costs you less because dentists who participate will not balance bill you. Diagnostic & Preventive Services are covered 100% and Basic Restoration Services are covered at 80%. Major Services are covered at 50%.

If you use an out-of-network dentist, payment will be made directly to you and you will be responsible for paying the dentist any excess charges above the allowed amount.

Delta Dental network dentists agree to accept Delta Dental's payment as payment in full for covered services less applicable coinsurance and deductibles. Out-of-network dentists are under no obligation to accept the payment as full payment, and may bill you for the difference between the billed charges and the allowed amount.

To see a list of dentists participating in the Delta Dental's network, pick up a provider directory at a Paper Depot or go online to www.deltadentalaz.com.

Delta Dental's Features	
Annual Year Maximum per person	$2,000
Orthodontic Service	Diagnostic, active and retention treatment: 50% Covers adults and children age 8 and older. Benefits are limited to a maximum of $3,000 per lifetime of the patient. This orthodontic maximum is separate from the Benefit Year maximum.
Provider Network Access	In-network and out-of-network providers are available statewide and anywhere in the United States as well as out of the country.

Deductible	$50 per person/$100 per family (waived for routine and orthodontic services).
Routine Services	100% coverage DIAGNOSTIC Exams, evaluations or consultations (twice in a benefit year) X-rays: Full mouth/Panorex or vertical bitewings (once in a three-year period); bitewings (twice in a benefit year); periapical. PREVENTIVE: Routine cleanings (limited to twice in a benefit year, or one difficult cleaning is limited to not more than once in a five-year period.) Topical application of fluoride (children through age 17 – twice in a benefit year) Sealants for children (once per three-year period for permanent molars & bicuspids up to age 19) Space maintainers [for missing posterior primary (baby) teeth] EMERGENCY: (Palliative treatment) Treatment for the relief of pain
Orthodontic Service	Diagnostic, active and retention treatment: 50% Covers adults and children $3,000 lifetime maximum effective for treatment plans beginning on or after Jan. 1, 2005. Lifetime maximum will be coordinated with prior group insurance carrier; continuing services previously covered under a prepaid dental plan, such as EDS, will not be covered.
Basic Services	80% coverage RESTORATIVE: Fillings consisting of silver amalgam on posterior teeth Synthetic fillings on anterior teeth Stainless steel crowns [for primary (baby) teeth only] Oral surgery: extractions Endodontics: Root canal treatment (permanent teeth); pulpotomy [primary (baby) teeth] Periodontics: Treatment of gum disease (non-surgical – once every two years; surgical – once every three years); periodontal maintenance following periodontal treatment (limited to two cleanings per year in addition to routine cleanings) BRIDGE AND DENTURE REPAIR: Repair of such appliances to their original condition including relining of dentures.
Major Services	50% coverage PROSTHODONTICS (Does not provide for lost, misplaced or stolen bridges or dentures. Five-year waiting period for replacement since last performed) Bridges Partial dentures Complete dentures RESTORATIVE: (Five-year waiting period for replacement since last performed) Cast crowns Jackets Onlays Inlays Synthetic posterior fillings Implants (must meet dental criteria)

Monthly COBRA Premium Rates

Medical Plans

Medical plans premiums include coverage for medical, pharmacy, behavioral health and substance abuse, and vision.

HealthSelect Medical Plan with Coinsurance Rx Plan

Employee	$373.16
Employee + Spouse	$745.66
Employee + Child(ren)	$617.22
Employee + Family	$990.99

HealthSelect Medical Plan with Consumer Choice Rx Plan

Employee	$330.81
Employee + Spouse	$660.88
Employee + Child(ren)	$547.29
Employee + Family	$878.71

CIGNA Medical Plan Premium Rates

CIGNA HMO CMG High Option Medical Plan with Coinsurance Rx Plan

Employee	$378.46
Employee + Spouse	$756.27
Employee + Child(ren)	$625.91
Employee + Family	$1,005.03

CIGNA HMO CMG High Option Medical Plan with Consumer Choice Rx Plan

Employee	$336.11
Employee + Spouse	$671.49
Employee + Child(ren)	$555.98
Employee + Family	$892.74

CIGNA HMO CMG Low Option Medical Plan with Coinsurance Rx Plan

Employee	$310.81
Employee + Spouse	$621.02
Employee + Child(ren)	$514.77
Employee + Family	$825.87

CIGNA HMO CMG Low Option Medical Plan with Consumer Choice Rx Plan

Employee	$268.46
Employee + Spouse	$536.23
Employee + Child(ren)	$444.84
Employee + Family	$713.59

CIGNA HMO IPA Medical Plan with Coinsurance Rx Plan

Employee	$409.47
Employee + Spouse	$818.28
Employee + Child(ren)	$676.91
Employee + Family	$1,087.20

CIGNA HMO IPA Medical Plan with Consumer Choice Rx Plan

Employee	$367.12
Employee + Spouse	$733.50
Employee + Child(ren)	$606.98
Employee + Family	$974.92

CIGNA OAP High Option Medical Plan with Coinsurance Rx Plan

Employee	$440.35
Employee + Spouse	$880.06
Employee + Child(ren)	$727.71
Employee + Family	$1,169.08

CIGNA OAP High Option Medical Plan with Consumer Choice Rx Plan

Employee	$398.00
Employee + Spouse	$795.27
Employee + Child(ren)	$657.78
Employee + Family	$1,056.80

CIGNA OAP Low Option Medical Plan with Coinsurance Rx Plan

Employee	$330.44
Employee + Spouse	$660.23
Employee + Child(ren)	$546.96
Employee + Family	$877.77

CIGNA OAP Low Option Medical Plan with Consumer Choice Rx Plan

Employee	$288.09
Employee + Spouse	$575.44
Employee + Child(ren)	$477.03
Employee + Family	$765.49

CIGNA Health Savings Account CIGNA Choice Fund Medical Plan Premium Rates

Employee	$369.73
Employee + Spouse	$738.97
Employee + Child(ren)	$611.14
Employee + Family	$982.26

Vision Plan

Vision Stand Alone Plan Premium Rates
100% Paid by Employee

	Cost
Employee	$3.79
Employee and Spouse	$7.10
Employee and Child(ren)	$9.55
Employee and Family	$12.53

Dental Plan Premium Rates

Employers Dental Services (EDS) Premium Rates
A Managed Care Dental Organization

Employee	$9.87
Employee + Spouse	$18.77
Employee + Child(ren)	$24.60
Employee + Family	$28.36

CIGNA Dental Premium Rates
A PPO Dental Plan

Employee	$31.33
Employee + Spouse	$69.12
Employee + Child(ren)	$74.75
Employee + Family	$96.08

Delta Dental Premium Rates
A PPO Dental Plan

Employee	$37.37
Employee + Spouse	$82.42
Employee + Child(ren)	$89.15
Employee + Family	$114.61

Glossary of Terms

Coinsurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a percentage of the costs of covered services after payment of the deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as $20 for an office visit). The amount does not vary with the cost of the service, unlike coinsurance, which is based on a percentage of cost.

CMG (CIGNA Medical Group) Network: A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the IPA network when a referral is made by the CMG physician..

Deductible(s): Under a health insurance contract, amounts required to be paid by the insured either before benefits become payable, after a portion of benefits have been paid or for a specific benefit, before benefits are payable.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals and other health professionals, who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

Health Savings Account: A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

HMO CMG Plan: A managed-care plan that requires members to use the CMG network for primary and most specialty and other services. Use of non-network providers or providers in private practice is not covered.

HMO IPA Plan: A managed-care plan that uses both the CMG network plus the larger IPA network of providers which includes physicians who practice in private offices. Use of non-network providers is not covered.

Insured: A person or organization covered by an insurance policy.

Insurer (Insurance Company): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

IPA (Independent Physician Association) Network: A network of providers who practice in their own private practice offices and independently contract with CIGNA. The IPA network also includes the CMG network.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and coinsurance.

OAP (Open Access Plus) Plan: A plan that gives options to use a network or non-network physician each time the insured needs medical care and requires no referral to see a specialist. The OAP uses the national IPA network.

Preferred Drug List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred drug list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

WHO TO CONTACT Effective Jan. 1, 2006

Company	Phone	Web Site & E-mail Addresses
Employee Benefits		
Maricopa County Benefits Office Maricopa County Administration Building 301 West Jefferson St., Suite 201 Phoenix, Arizona 85003-2145	602-506-1010 Fax: 602-506-2354	Benefits Home Page: Internet: www.maricopa.gov/benefits Intranet: ebc.maricopa.gov/hr/benefits E-mail: BenefitsService@mail.maricopa.gov
Medical Plans		
CIGNA Customer Service Group # 3205496 Pre-Enrollment Phone Line	800-244-6224 800-564-7642	Internet: www.cigna.com Internet: www.mycigna.com
HealthSelect Customer Service Group # 3310592	800-244-6224	Internet: www.cigna. com Internet: www.mycigna.com
24-Hour Health Information Line (for CIGNA and HealthSelect members)	800-564-8982	
Pharmacy Plan		
Walgreens Health Initiatives Member Services Group # 512229 Prior Authorization Walgreens Mail Service Member Service Mail Service Refills	800-207-2568 877-665-6609 888-265-1953 800-797-3345	Internet: www.mywhi.com
Behavioral Health		
United Behavioral Health (for HealthSelect and all CIGNA medical plans except CIGNA Choice Fund Health Savings Account) Group # 12488	866-312-3078	Internet: www.liveandworkwell.com Access Code 12488
CIGNA Behavioral Health (for CIGNA Choice Fund Health Savings Account) Group # 3205496	800-244-6224	Internet: www.cigna.com Internet: www.mycigna.com
ComPsych Guidance Resources: EAP	888-355-5385	Internet: www.guidanceresources.com ID: MC2003
Vision		
Avesis (for HealthSelect and all CIGNA medical plans) Plan # 943 Group # 910790-95-01 (all medical plans) Group # 10790-2016-943 (if waived medical coverage and elected stand alone vision)	800-828-9341	Internet: www.avesis.com E-mail: info@avesis.com
Dental		
Employers Dental Services Group # 11931	602-248-8912 800-722-9772	Internet: www.mydentalplan.net
CIGNA Dental Group # 2465354	888-336-8258	Internet: www.cigna.com Internet: www.mycigna.com
Delta Dental Group # 4500	602-938-3131 800-352-6132	Internet: www.deltadentalaz.com
Life Insurance		
UNUMProvident Customer Service Life Group # 584741 AD&D Group # GSR 36743 and GSR 36744	800-421-0344	Internet: www.unum.com
Short-Term and Long-Term Disability		
VPA, Inc	800-495-9301	Internet: www.vpainc.com
Other Frequently Requested Information		
Arizona State Retirement System Outside Phoenix	602-240-2000 800-621-3778	Internet: www.asrs.state.az.us
Public Safety Retirement System	602-255-5575	Internet: www.psprs.com
ASI (Mariflex Administrator): Flexible Spending Accounts	800-659-3035	Internet: www.asiflex.com E-mail: asi@asiflex.com
Liberty Mutual: Auto, Home and Renters Insurance	800-221-8135	Internet: www.libertymutual.com
Nationwide Retirement Solutions: Deferred Compensation	602-266-2733 800-653-4632	Internet: www.maricopadc.com
Trustmark: Critical Illness Coverage	480-991-4444, ext. 15	E-mail: enrollment@einsteinbenefit.com